FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040444

Facility Name: Sheridan Shores Care

Address: 5838 North Sheridan (Number) Chicago (City) 60660 (Zip Code)

County: Cook

Telephone Number: (773) 769-2230 **Fax #** (773) 769-3579

IDPA ID Number: 363873049001

Date of Initial License for Current Owners: 06/04/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	127	Skilled (SNF)	127	46,482	1
2		Skilled Pediatric (SNF/PED)			2
3	61	Intermediate (ICF)	61	22,326	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	188	TOTALS	188	68,808	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,637	206	1,691	15,534	8
9	SNF/PED					9
10	ICF	48,273	480		48,753	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,910	686	1,691	64,287	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.43%

D. How many bed-hold days during this year were paid by Public Aid?
954 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 31 and days of care provided 1,691

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	213,134	35,744	12,629	261,507		261,507	3,064	264,571			1
2	Food Purchase		237,623		237,623	(27,670)	209,953	1,166	211,119			2
3	Housekeeping	156,626	35,305		191,931		191,931	(4,773)	187,158			3
4	Laundry	69,870	15,840	517	86,227		86,227		86,227			4
5	Heat and Other Utilities			148,951	148,951		148,951	(4,037)	144,914			5
6	Maintenance	139,347		86,448	225,795		225,795	(2,404)	223,391			6
7	Other (specify):*							1,563	1,563			7
8	**TOTAL General Services**	578,977	324,512	248,545	1,152,034	(27,670)	1,124,364	(5,421)	1,118,944			8
	B. Health Care and Programs											
9	Medical Director			4,900	4,900		4,900		4,900			9
10	Nursing and Medical Records	1,835,564	31,300	9,341	1,876,205		1,876,205	15,820	1,892,025			10
10a	Therapy	48,017			48,017		48,017	(3)	48,014			10a
11	Activities	110,894	15,225	2,130	128,249		128,249		128,249			11
12	Social Services	181,257	558	1,761	183,576		183,576	11,556	195,132			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							4,683	4,683			15
16	**TOTAL Health Care and Programs**	2,175,732	47,083	18,132	2,240,947		2,240,947	32,056	2,273,003			16
	C. General Administration											
17	Administrative	80,624		48,000	128,624		128,624	14,675	143,299			17
18	Directors Fees											18
19	Professional Services			146,590	146,590	(4,235)	142,355	(71,357)	70,998			19
20	Dues, Fees, Subscriptions & Promotions			31,104	31,104		31,104	(2,493)	28,611			20
21	Clerical & General Office Expenses	73,861	24,991	119,851	218,703		218,703	83,285	301,988			21
22	Employee Benefits & Payroll Taxes			553,585	553,585	27,670	581,255	(824)	580,431			22
23	Inservice Training & Education			2,764	2,764		2,764		2,764			23
24	Travel and Seminar			3,728	3,728		3,728	4,300	8,028			24
25	Other Admin. Staff Transportation			544	544		544		544			25
26	Insurance-Prop.Liab.Malpractice			176,254	176,254		176,254	279	176,533			26
27	Other (specify):*							23,114	23,114			27
28	**TOTAL General Administration**	154,485	24,991	1,082,420	1,261,896	23,435	1,285,331	50,979	1,336,310			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,909,194	396,586	1,349,097	4,654,877	(4,235)	4,650,642	77,614	4,728,256			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sheridan Shores Care #0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			61,080	61,080		61,080	93,798	154,878			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			207,109	207,109		207,109	5	207,114			32
33	Real Estate Taxes			177,154	177,154	4,235	181,389	1,985	183,374			33
34	Rent-Facility & Grounds			1,077,334	1,077,334		1,077,334	5,178	1,082,512			34
35	Rent-Equipment & Vehicles			4,818	4,818		4,818	1,931	6,749			35
36	Other (specify):*			3,178	3,178		3,178	9,759	12,937			36
37	**TOTAL Ownership**			1,530,673	1,530,673	4,235	1,534,908	112,656	1,647,564			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		100,534	83,283	183,817		183,817	(5,389)	178,428			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			103,212	103,212		103,212		103,212			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		100,534	186,495	287,029		287,029	(5,389)	281,640			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,909,194	497,120	3,066,265	6,472,579		6,472,579	184,881	6,657,460			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,644)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	77,867	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(25)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(43)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(70,642)	21		24
25	Fund Raising, Advertising and Promotional	(2,431)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(20,055)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (20,974)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	205,855		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 205,855		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 184,881		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Sheridan Shores Care

ID# 0040444

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty Income	$ (86)	10	1
2	Patient Clothing	(1,234)	10	2
3	Non-Allowable Legal Fees	(501)	19	3
4	Non-Allowable Legal Fees	(1,515)	19	4
5	COPE Dues	(3,017)	20	5
6				6
7	Misc. Income	(3,850)	21	7
8				8
9	PPA - Insurance Premiums	(622)	26	9
10	Capitalized R&M	(9,230)	06	10
11				11
12				12
13				13
14				14
15				15
16				16
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95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(20,055)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(280)	421		3,836	(913)				3,064	1
2	Food Purchase	(25)							1,191				1,166	2
3	Housekeeping				(4,773)								(4,773)	3
4	Laundry													4
5	Heat and Other Utilities	(5,644)				1,607							(4,037)	5
6	Maintenance	(9,230)			(625)	1,716		5,723	12				(2,404)	6
7	Other (specify):*							1,398	165				1,563	7
8	**TOTAL General Services**	(14,899)			(5,678)	3,744		10,957	455				(5,421)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,320)			(2,861)			20,001					15,820	10
10a	Therapy				(3)								(3)	10a
11	Activities													11
12	Social Services							11,556					11,556	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*						66	4,617					4,683	15
16	**TOTAL Health Care and Programs**	(1,320)			(2,864)		66	36,174					32,056	16
	C. General Administration													
17	Administrative							14,594	81				14,675	17
18	Directors Fees													18
19	Professional Services	(2,016)				(69,349)			8				(71,357)	19
20	Fees, Subscriptions & Promotions	(5,491)				2,993			5				(2,493)	20
21	Clerical & General Office Expenses	(74,492)				15,672		141,959	146				83,285	21
22	Employee Benefits & Payroll Taxes			(347)			(477)						(824)	22
23	Inservice Training & Education													23
24	Travel and Seminar					4,264			36				4,300	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(622)				870			31				279	26
27	Other (specify):*						399	22,715					23,114	27
28	**TOTAL General Administration**	(82,621)		(347)		(45,550)	(78)	179,268	307				50,979	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(98,840)		(347)	(8,541)	(41,806)	(12)	226,399	762				77,614	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheridan Shores Care # 0040444 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	77,867				15,931							93,798	30
31	Amortization of Pre-Op. & Org.													31
32	Interest								5				5	32
33	Real Estate Taxes					1,985							1,985	33
34	Rent-Facility & Grounds					5,010			168				5,178	34
35	Rent-Equipment & Vehicles					1,927			4				1,931	35
36	Other (specify):*		9,759										9,759	36
37	**TOTAL Ownership**	77,867	9,759			24,853			177				112,656	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(2,993)				(2,396)				(5,389)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**				(2,993)				(2,396)				(5,389)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(20,974)	9,759	(347)	(11,534)	(16,953)	(12)	226,399	(1,457)				184,881	45

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		34	Rent Income/Expense	$ 1,077,334	Edgewater Care & Rehab Center Building, LLC	100.00%	$ 1,077,334	$	1
2	V		33	Rental Income/Expense - RE Tax	186,765	Edgewater Care & Rehab Center Building, LLC	100.00%	186,765		2
3	V		36	Amortization Expense		Edgewater Care & Rehab Center Building, LLC	100.00%	9,759	9,759	3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 1,264,099			$ 1,273,858	$ * 9,759	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 63,914	$ 63,914	15
16	V									16
17	V									17
18	V									18
19	V		22	EMPLOYEE HEALTH INSURANCE	64,261	CCS EMPLOYEE BENEFIT GROUP	100.00%		(64,261)	19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 64,261			$ 63,914	$ * (347)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ 1,888	XCEL MEDICAL SUPPLY, LLC	100.00%	$ 1,608	$ (280)	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	32,168	XCEL MEDICAL SUPPLY, LLC	100.00%	27,396	(4,773)	17
18	V	04	LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06	REPAIRS & MAINTENANCE	4,214	XCEL MEDICAL SUPPLY, LLC	100.00%	3,588	(625)	19
20	V	10	NURSING	19,284	XCEL MEDICAL SUPPLY, LLC	100.00%	16,423	(2,861)	20
21	V	10A	THERAPY	19	XCEL MEDICAL SUPPLY, LLC	100.00%	16	(3)	21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%			24
25	V	39	ANCILLARY	20,173	XCEL MEDICAL SUPPLY, LLC	100.00%	17,180	(2,993)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 77,745			$ 66,211	$ * (11,534)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 421	$ 421	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,607	1,607	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	1,716	1,716	17
18	V	10	Nursing		Care Centers, Inc.	100.00%			18
19	V	11	Activities		Care Centers, Inc.	100.00%			19
20	V	19	Professional Fees	78,000	Care Centers, Inc.	100.00%	8,651	(69,349)	20
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	2,993	2,993	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	15,672	15,672	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	4,264	4,264	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	870	870	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	15,931	15,931	25
26	V	32	Interest		Care Centers, Inc.	100.00%			26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,985	1,985	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	5,010	5,010	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,927	1,927	29
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			30
31	V	02	Food		Care Centers, Inc.	100.00%			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 78,000			$ 61,047	$ * (16,953)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$	Care Centers, Inc.	100.00%	$	$	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%			16
17	V	10	Nursing Salary	450	Care Centers, Inc.	100.00%	450		17
18	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			18
19	V	11	Activity Salary		Care Centers, Inc.	100.00%			19
20	V	12	Social Service Salary		Care Centers, Inc.	100.00%			20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	66	66	21
22	V	17	Administration Salary		Care Centers, Inc.	100.00%			22
23	V	21	Office Salary	2,727	Care Centers, Inc.	100.00%	2,727		23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	399	399	24
25	V	22	Employee Benefits	477	Care Centers, Inc.	100.00%		(477)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 3,654			$ 3,642	$ * (12)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$	Care Centers, Inc.	100.00%	$ 3,836	$ 3,836	15
16	V	03	Housekeeping Salary		Care Centers, Inc.	100.00%			16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	5,723	5,723	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,398	1,398	18
19	V	10	Nursing Salary		Care Centers, Inc.	100.00%	20,001	20,001	19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			20
21	V	12	Social Services Salary		Care Centers, Inc.	100.00%	11,556	11,556	21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	4,617	4,617	22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	14,594	14,594	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	141,959	141,959	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	22,715	22,715	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 226,399	$ * 226,399	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 2,354	Care Centers, Inc. - Health Systems Division	100.00%	$ 313	$ (2,041)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	1,191	1,191	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	12	12	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	81	81	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	8	8	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	5	5	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	146	146	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	36	36	22
23	V	26	Insurance		Care Centers, Inc. - Health Systems Division	100.00%	31	31	23
24	V	32	Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	5	5	24
25	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	168	168	25
26	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	4	4	26
27	V	39	Ancillary Enteral Supplies	4,851	Care Centers, Inc. - Health Systems Division	100.00%	2,455	(2,396)	27
28	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	1,128	1,128	28
29	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	165	165	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,205			$ 5,748	$ * (1,457)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Eric Rothner	Owner	Administrative	19.14%	See Attached	1.35	2.93%		$		1
2	Norm Goldberg	Owner	Administrative	2.13%	See Attached	1.50	3.00%	Alloc Salary	4,074	17-7	2
3	Mark Steinberg	Relative	Administrative		See Attached	0	0	Alloc Salary	2,618	17-7	3
4	Adam Vales	Relative	Clerical		See Attached	0.42	1.05%	Alloc Salary	431	22-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 7,123		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURA	DIRECT ALLOCATION			$	$		$ 63,914	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 63,914	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$ 1,608	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						27,396	3
4	04	LAUNDRY	Direct Allocation							4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						3,588	5
6	10	NURSING	Direct Allocation						16,423	6
7	10A	THERAPY	Direct Allocation						16	7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation							10
11	39	ANCILLARY	Direct Allocation						17,180	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 66,211	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,484,397	42	$ 9,730	$	64,287	$ 421	1
2	05	Utilities	Patient Days	1,484,397	42	37,103		64,287	1,607	2
3	06	Maintenance	Patient Days	1,484,397	42	39,622		64,287	1,716	3
4	10	Nursing	Patient Days	1,484,397	42			64,287		4
5	11	Activities	Patient Days	1,484,397	42			64,287		5
6	19	Professional Fees	Patient Days	1,484,397	42	199,755		64,287	8,651	6
7	20	Dues and Subscriptions	Patient Days	1,484,397	42	69,116		64,287	2,993	7
8	21	Office & Clerical	Patient Days	1,484,397	42	361,868		64,287	15,672	8
9	24	Travel and Seminar	Patient Days	1,484,397	42	98,454		64,287	4,264	9
10	26	Insurance	Patient Days	1,484,397	42	20,081		64,287	870	10
11	30	Depreciation	Patient Days	1,484,397	42	367,842		64,287	15,931	11
12	32	Interest	Patient Days	1,484,397	42			64,287		12
13	33	Real Estate Taxes	Patient Days	1,484,397	42	45,838		64,287	1,985	13
14	34	Rent - Building	Patient Days	1,484,397	42	115,677		64,287	5,010	14
15	35	Rent - Equipment & Auto	Patient Days	1,484,397	42	44,486		64,287	1,927	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,409,572	$		$ 61,047	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			264,919	264,919			1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			38,757				2
3	10	Nursing Salary	Direct Cost			209,584	209,584		450	3
4	10a	Rehab Salary	Direct Cost			66,982	66,982			4
5	11	Activity Salary	Direct Cost							5
6	12	Social Service Salary	Direct Cost			66,710	66,710			6
7	15	Emp. Ben. - Healthcare	Direct Cost			50,220			66	7
8	17	Administration Salary	Direct Cost			38,431	38,431			8
9	21	Office Salary	Direct Cost			525,935	525,935		2,727	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			82,566			399	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,344,103	$ 1,172,560		$ 3,642	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,484,397	42	88,579	88,579	64,287	3,836	1
2	03	Housekeeping Salary	Patient Days	1,484,397	42			64,287		2
3	06	Maintenance Salary	Patient Days	1,484,397	42	132,146	132,146	64,287	5,723	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,484,397	42	32,292		64,287	1,398	4
5	10	Nursing Salary	Patient Days	1,484,397	42	461,827	461,827	64,287	20,001	5
6	10a	Rehab Salary	Patient Days	1,484,397	42			64,287		6
7	12	Social Services Salary	Patient Days	1,484,397	42	266,840	266,840	64,287	11,556	7
8	15	Emp. Ben. - Healthcare	Patient Days	1,484,397	42	106,602		64,287	4,617	8
9	17	Administration Salary	Patient Days	1,484,397	42	336,976	336,976	64,287	14,594	9
10	21	Office Salary	Patient Days	1,484,397	42	3,277,864	3,277,864	64,287	141,959	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,484,397	42	524,485		64,287	22,715	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,227,610	$ 4,564,232		$ 226,399	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,144,835		93,149		7,204	313	1
2	02	Food	Billable Income	2,144,835		987,169		7,204	1,191	2
3	06	Maintenance	Billable Income	2,144,835		3,597		7,204	12	3
4	17	Administration	Billable Income	2,144,835		24,000		7,204	81	4
5	19	Professional Fees	Billable Income	2,144,835		2,500		7,204	8	5
6	20	Dues & Subscriptions	Billable Income	2,144,835		1,342		7,204	5	6
7	21	Office & Clerical	Billable Income	2,144,835		43,384		7,204	146	7
8	24	Travel & Seminar	Billable Income	2,144,835		10,755		7,204	36	8
9	26	Insurance	Billable Income	2,144,835		9,262		7,204	31	9
10	32	Interest Expense	Billable Income	2,144,835		1,371		7,204	5	10
11	34	Rent - Building	Billable Income	2,144,835		50,000		7,204	168	11
12	35	Rent - Equipment & Auto	Billable Income	2,144,835		1,080		7,204	4	12
13	39	Ancillary Enteral Supplies	Billable Income	2,144,835		98,519		7,204	2,455	13
14	01	Dietary - Salary	Billable Income	2,144,835		335,801	335,801	7,204	1,128	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	2,144,835		49,127		7,204	165	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,711,055	$ 335,801		$ 5,748	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Diawa		X	Line of Credit				2,701,417			207,110	6
7												7
8	See Supplemental Schedule										5	8
9	TOTAL Facility Related						$	$ 2,701,417			$ 207,115	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 2,701,417			$ 207,115	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocate Care Centers		X				$	$			$ 5	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										5	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	263,159	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	216,772	2
3. Under or (over) accrual (line 2 minus line 1).	$	(46,387)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	225,526	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	4,235	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	183,374	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	284,769	8
	2000	241,566	9
	2001	247,849	10
	2002	250,628	11
	2003	214,787	12

2004 Accrual - $214,787 X 1.05 = $225,526

Care Centers Allocation - $1,985

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Shores Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040444

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-05-402-027-0000	Long Term Care Property	$ 107,393.60	$ 107,393.60
2.	14-05-402-028-0000	Long Term Care Property	$ 107,393.60	$ 107,393.60
3.	Home Office	See Attached	$ 106,873.39	$ 1,985.17
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 321,660.59	$ 216,772.37

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Shores Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040444

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	2201 Main LLC Allocation			$ 15,232	1
2					2
3	TOTALS			$ 15,232	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	42,874		20	2,145	2,145	24,309	9
10	Various			1994	57,552		20	2,878	2,878	30,444	10
11	Various			1995	146,433		20	7,322	7,322	70,687	11
12	Various			1996	67,704		20	3,385	(3,385)	29,093	12
13	Various			1997	53,902		20	2,696	2,696	20,349	13
14	Various			1998	172,679		20	8,637	8,637	56,959	14
15	Various			1999	62,682		20	3,134	3,134	17,427	15
16	Various			2000	149,525		20	7,503	7,503	33,899	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)								67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		58,763	2,414		2,414		5,012	68
69	Financial Statement Depreciation			61,080			(61,080)		69
70	TOTAL (lines 4 thru 69)		$ 812,114	$ 63,494		$ 40,114	$ (30,150)	$ 288,179	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 812,114	$ 63,494		$ 40,114	$ (23,380)	$ 288,179	1
2	Expansion Tank	2001	572		20	29	29	115	2
3	Pipe Insulation	2001	956		20	48	48	191	3
4	Pilot Assembly	2001	518		20	26	26	104	4
5	Motor	2001	1,135		20	57	57	227	5
6	Motor	2001	1,386		20	69	69	271	6
7	Transmitter	2001	924		20	46	46	181	7
8	Wiring	2001	1,274		20	64	64	250	8
9	Generator	2001	589		20	29	29	115	9
10	Paint	2001	924		20	46	46	174	10
11	Cubicle Curtains	2001	17,136		20	857	857	3,356	11
12	Elevator	2001	1,522		20	76	76	285	12
13	Air Conditioning	2001	1,294		20	65	65	237	13
14	Compressor	2001	1,218		20	61	61	219	14
15	Sewer Lines	2001	3,692		20	185	185	662	15
16	Window Coverings	2001	2,328		20	116	116	407	16
17	Domestic Water Pipin	2001	548		20	27	27	93	17
18	Wiring	2001	1,140		20	57	57	228	18
19	Transmitter	2001	924		20	46	46	185	19
20	Steel Door	2001	1,199		20	60	60	205	20
21	Wiring	2001	4,785		20	239	239	957	21
22	Drywall	2001	638		20	32	32	128	22
23	Flame Control Center	2001	1,402		20	70	70	263	23
24	Cubicle Curtains	2001	693		20	35	35	127	24
25	Fire Alarm	2001	800		20	40	40	147	25
26	Transmitter	2001	940		20	47	47	172	26
27	Flow Switch	2001	765		20	38	38	140	27
28	Steel Shutes, Door	2001	1,332		20	67	67	234	28
29	Exhaust System	2001	543		20	27	27	92	29
30	Fedders	2001	5,285		20	264	264	903	30
31	Hot Water Heater	2002	11,675		20	1,168	1,168	3,405	31
32	Toilet R & M	2002	747		20	75	75	224	32
33	Ceiling Fans	2002	700		20	70	70	210	33
34	TOTAL (lines 1 thru 33)		$ 881,698	$ 63,494		$ 44,250	$ (19,244)	$ 302,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 881,698	$ 63,494		$ 44,250	$ (19,244)	$ 302,686	1
2	Doors	2002	1,199		20	60	60	180	2
3	Deposit On Don Office Remodeling	2002	1,859		20	186	186	558	3
4	Water Pump Leaking	2002	2,449		20	245	245	735	4
5	Roof Maintenance	2002	3,800		20	380	380	1,140	5
6	Electric Wiring	2002	615		20	62	62	185	6
7	New Water Pressure Valve	2002	656		20	131	131	394	7
8	Nurse Call System	2002	2,100		20	140	140	420	8
9	Tile Outlet-Tiles	2002	990		20	66	66	193	9
10	Elevator Repair	2002	1,110		20	56	56	157	10
11	Plumbing Repair	2002	565		20	57	57	160	11
12	Boiler Repair	2002	594		20	50	50	136	12
13	Cooling Tower Repair	2002	541		20	54	54	149	13
14	A/C Repair	2002	852		20	71	71	195	14
15	Power Tron Repair	2002	1,791		20	179	179	493	15
16	Countertops	2002	2,300		20	230	230	633	16
17	Plumbing Repair	2002	690		20	69	69	184	17
18	Boiler Repair	2002	1,334		20	111	111	296	18
19	Doors	2002	1,050		20	53	53	140	19
20	Sump Pump R & M	2002	2,214		20	221	221	572	20
21	Plumbing Repair	2002	824		20	82	82	213	21
22	Plumbing Repair	2002	2,940		20	294	294	760	22
23	Antennas	2002	1,065		20	213	213	550	23
24	Door	2002	635		20	32	32	82	24
25	Hvac Feeders	2002	5,252		20	438	438	1,131	25
26	Freezer R&M	2002	1,848		20	264	264	660	26
27	Hvac R&M	2002	599		20	60	60	150	27
28	Antennas	2002	1,065		20	213	213	533	28
29	Timeclock Installation	2002	759		20	152	152	367	29
30	Ceiling Tile	2002	758		20	38	38	88	30
31	Powertron Repair	2002	777		20	78	78	201	31
32	Booster Circuit For Water Booster	2002	516		20	52	52	142	32
33	Roof	2002	1,050		20	105	105	236	33
34	TOTAL (lines 1 thru 33)		$ 926,495	$ 63,494		$ 48,692	$ (14,802)	$ 314,719	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 926,495	$ 63,494		$ 48,692	$ (14,802)	$ 314,719	1
2	Vertical Blinds	2002	2,034		20	203	203	458	2
3	Boiler	2002	1,876		20	188	188	422	3
4	Drywall	2002	850		20	85	85	191	4
5	Electric	2002	826		20	165	165	372	5
6	Bathroom Remodeling	2002	3,276		20	328	328	956	6
7	Water Heater	2003	2,282		20	456	456	913	7
8	Keypad Panel W/ Transformer	2003	1,538		20	308	308	615	8
9	Keypad Panel W/ Transformer	2003	1,070		20	214	214	428	9
10	Plumbing Repair	2003	570		20	57	57	114	10
11	Doors	2003	1,315		20	263	263	526	11
12	Elevator Repairs	2003	1,229		20	123	123	246	12
13	Ejector Pump	2003	2,741		20	548	548	1,096	13
14	Boiler Repairs	2003	1,389		20	139	139	278	14
15	Water Heater	2003	808		20	162	162	310	15
16	Roofing	2003	700		20	70	70	134	16
17	Roofing	2003	700		20	70	70	128	17
18	Roofing	2003	700		20	70	70	128	18
19	First Floor Construction	2003	9,833		20	983	983	1,803	19
20	Pipeing	2003	5,854		20	585	585	1,073	20
21	Hvac Repairs	2003	2,669		20	534	534	979	21
22	Plumbing Repair	2003	670		20	134	134	246	22
23	Lobby Remodeling	2003	10,500		20	1,050	1,050	1,838	23
24	Bathroom Remodeling	2003	1,850		20	185	185	324	24
25	Painting Material	2003	542		20	108	108	190	25
26	Lobby Remodeling - Addl Work	2003	2,501		20	250	250	417	26
27	Elevator Repair	2003	661		20	132	132	220	27
28	Elevator Repair	2003	823		20	165	165	274	28
29	Wall Repair	2003	774		20	77	77	129	29
30	Cooling Tower	2003	1,652		20	330	330	551	30
31	Nurses Call Repair	2003	665		20	133	133	222	31
32	First Floor Construction	2003	588		20	59	59	93	32
33	Hot Water Heater Repair	2003	857		20	171	171	271	33
34	TOTAL (lines 1 thru 33)		$ 990,838	$ 63,494		$ 57,037	$ (6,457)	$ 330,664	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 990,838	$ 63,494		$ 57,037	$ (6,457)	$ 330,664	1
2	Birch Fire Door	2003	5,574		20	1,115	1,115	1,672	2
3	Parking Garage Repairs	2003	1,925		20	193	193	289	3
4	Parking Garage Repairs	2003	2,709		20	271	271	384	4
5	2 Lavatories	2003	1,216		20	243	243	345	5
6	Parking Garage Repair	2003	4,770		20	477	477	636	6
7	Boiler Repair	2003	3,630		20	726	726	968	7
8	Parts For Door	2003	784		20	157	157	209	8
9	Detector Edge In Elevator	2003	556		20	111	111	148	9
10	Storage Tank	2003	2,323		20	465	465	581	10
11	Security System Key Switches	2003	885		20	177	177	221	11
12	Door Locks	2003	2,017		20	403	403	504	12
13	Parking Garage Repair	2003	3,693		20	369	369	431	13
14	Smoke Detectors Installed	2003	4,021		20	804	804	938	14
15	Pump W/ Motor	2003	977		20	195	195	228	15
16	Repairs And Parts For Boiler*	2004	658		20	121	121	121	16
17	Repairs And Parts For Exhaust Fans*	2004	1,227		20	225	225	225	17
18	Bypass Hoses & Exhaust System*	2004	2,814		20	516	516	516	18
19	Generator Repair*	2004	3,790		20	347	347	347	19
20	New Motor*	2004	926		20	154	154	154	20
21	Repair Of Air Conditioning System*	2004	1,768		20	265	265	265	21
22	Elevator Repairs	2004	500		20	67	67	67	22
23	Generator Maintenance	2004	1,171		20	137	137	137	23
24	Repair On Walk-In-Freezer	2004	501		20	58	58	58	24
25	Removal Of Heavy Duty Shoring	2004	3,373		20	169	169	169	25
26	Elevator Repair	2004	604		20	30	30	30	26
27	Elevator Repair	2004	604		20	50	50	50	27
28	Fire Service Upgrade	2004	35,300		20	1,471	1,471	1,471	28
29	New Compressor	2004	1,826		20	152	152	152	29
30	Heater Repair And Parts	2004	1,480		20	62	62	62	30
31	Door Signs	2004	544		20	45	45	45	31
32	Shower & Tub Rooms	2004	560		20	19	19	19	32
33	Tower & Exhaust Repairs	2004	614		20	20	20	20	33
34	TOTAL (lines 1 thru 33)		$ 1,084,178	$ 63,494		$ 66,651	$ 3,157	$ 342,126	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 1,084,178	$ 63,494		$ 66,651	$ 3,157	$ 342,126	1
2	Small Passenger Elevator Repairs	2004	1,661		20	42	42	42	2
3	Large Passenger Elevator Repairs	2004	955		20	24	24	24	3
4	Small Passenger Elevator Repairs	2004	604		20	10	10	10	4
5	Large Passenger Elevator Repairs	2004	1,435		20	36	36	36	5
6	Water Pump Repairs	2004	1,173		20	29	29	29	6
7	Safety Glass	2004	560		20	14	14	14	7
8	Elevator Repair	2004	623		20	10	10	10	8
9	Small Passenger Elevator Repairs	2004	2,325		20	39	39	39	9
10	Small Passenger Elevator Repairs	2004	2,325		20	39	39	39	10
11	New Carpeting	2004	2,337		20	56	56	56	11
12	New Floor Tile	2004	1,627		20	18	18	18	12
13	Generator Maintenance	2004	791		20	13	13	13	13
14	Fire Alarm System	2004	2,100		20	18	18	18	14
15	Small Elevator Repairs	2004	5,425		20	23	23	23	15
16	Large Elevator Repairs	2004	1,214		20	5	5	5	16
17	Circulating Pump In Boiler Room	2004	3,015		20	21	21	21	17
18	Domestic Hot Water	2004	526		20	4	4	4	18
19	Door Magnets, Wiring*	2004	200		20	10	10	10	19
20	Wiring*	2004	295		20	15	15	15	20
21	Wiring*	2004	380		20	19	19	19	21
22	Acoustical And Drywall*	2004	386		20	19	19	19	22
23	Acoustical And Drywall*	2004	386		20	19	19	19	23
24	Condensor Fan Motor*	2004	344		20	17	17	17	24
25	Scaffholding*	2004	6,614		20	331	331	331	25
26	Wiring*	2004	625		20	31	31	31	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,122,104	$ 63,494		$ 67,514	$ 4,020	$ 342,989	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 1,122,104	$ 63,494		$ 67,514	$ 4,020	$ 342,989	1
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4									4
5									5
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,122,104	$ 63,494		$ 67,514	$ 4,020	$ 342,989	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 1,122,104	$ 63,494		$ 67,514	$ 4,020	$ 342,989	1
2									2
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,122,104	$ 63,494		$ 67,514	$ 4,020	$ 342,989	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 1,122,104	$ 63,494		$ 67,514	$ 4,020	$ 342,989	1
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,122,104	$ 63,494		$ 67,514	$ 4,020	$ 342,989	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 1,122,104	$ 63,494		$ 67,514	$ 4,020	$ 342,989	1
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,122,104	$ 63,494		$ 67,514	$ 4,020	$ 342,989	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 1,122,104	$ 63,494		$ 67,514	$ 4,020	$ 342,989	1
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33									33
34	TOTAL (lines 1 thru 33)		$ 1,122,104	$ 63,494		$ 67,514	$ 4,020	$ 342,989	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
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SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
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65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main, LLC Allocation		2002		$ 20,990	$ 525		$ 525	$	$ 1,312	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2201 Main, LLC Allocation			2002	17,339	867	20	867		2,167	9
10	2201 Main, LLC Allocation			2003	20,434	1,022	20	1,022		1,533	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 58,763	$ 2,414		$ 2,414	$	$ 5,012	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 590,898	$ 5,042	$ 59,903	$ 54,861	10	$ 358,134	71
72	Current Year Purchases	78,809	6,256	25,242	18,986	10	25,242	72
73	Fully Depreciated Assets	43,792				10	43,792	73
74								74
75	TOTALS	$ 713,499	$ 11,298	$ 85,145	$ 73,847		$ 427,168	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated Care Centers			$ 29,581	$ 2,151	$ 2,151	$	5	$ 24,911	76
77	Allocated Care Centers			451	68	68		5	68	77
78										78
79										79
80	TOTALS			$ 30,032	$ 2,219	$ 2,219	$		$ 24,979	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,880,867	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 77,011	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 154,878	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 77,867	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 795,136	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	Edgewater LLC			$ 1,077,334			3
4	Additions							4
5	Allocate Care Centers				5,178			5
6								6
7	TOTAL				$ 1,082,512 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 6,749 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 47,919	$		$ 47,919	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			35,364			35,364	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				41,492		41,492	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						59,042		59,042	13
14	TOTAL			$		$ 83,283	$ 100,534		$ 183,817	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 9,506	$ 16,534	1
2	Cash-Patient Deposits	72,031	72,031	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,147,801	1,147,801	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	122,151	122,151	6
7	Other Prepaid Expenses	149,905	149,905	7
8	Accounts Receivable (owners or related parties)	20,651	20,651	8
9	Other(specify): See Attached Schedule	613,964	679,791	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,136,009	$ 2,208,864	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	905,682	905,682	15
16	Equipment, at Historical Cost	765,951	765,951	16
17	Accumulated Depreciation (book methods)	(761,194)	(761,194)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		43,919	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	451,200	451,200	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,361,639	$ 1,405,558	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,497,648	$ 3,614,422	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 878,270	$ 878,269	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	70,491	70,491	28
29	Short-Term Notes Payable	2,701,417	2,701,417	29
30	Accrued Salaries Payable	141,053	141,053	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,021	11,021	31
32	Accrued Real Estate Taxes(Sch.IX-B)	225,526	225,526	32
33	Accrued Interest Payable	123,254	123,254	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	996,856	1,475,722	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,147,888	$ 5,626,753	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,147,888	$ 5,626,753	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,650,240)	$ (2,012,331)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,497,648	$ 3,614,422	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,718,107)	1
2	Restatements (describe):		2
3	**Depreciation Adjustment**	(101,488)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,819,595)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	192,105	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(22,750)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 169,355	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,650,240)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,539,140	1
2	Discounts and Allowances for all Levels	(425,281)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,113,859	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	390,326	6
7	Oxygen	11,993	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 402,319	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	5,644	15
16	Rental of Facility Space		16
17	Sale of Drugs	45,130	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,677	19
20	Radiology and X-Ray	420	20
21	Other Medical Services	36,040	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 118,911	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	29,595	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 29,595	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,664,684	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,152,034	31
32	Health Care	2,240,947	32
33	General Administration	1,261,896	33
	B. Capital Expense		
34	Ownership	1,530,673	34
	C. Ancillary Expense		
35	Special Cost Centers	183,817	35
36	Provider Participation Fee	103,212	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,472,579	40
41	**Income before Income Taxes (line 30 minus line 40)****	192,105	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 192,105	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,808	1,858	$ 52,625	$ 28.32	1
2	Assistant Director of Nursing	2,144	2,296	59,229	25.80	2
3	Registered Nurses	10,055	11,467	280,448	24.46	3
4	Licensed Practical Nurses	28,008	31,003	624,654	20.15	4
5	Nurse Aides & Orderlies	82,717	88,673	786,467	8.87	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,719	4,116	48,017	11.67	8
9	Activity Director	1,824	2,048	28,161	13.75	9
10	Activity Assistants	10,696	11,253	82,733	7.35	10
11	Social Service Workers	11,877	12,855	181,257	14.10	11
12	Dietician					12
13	Food Service Supervisor	1,939	2,150	33,528	15.59	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,141	21,867	179,606	8.21	15
16	Dishwashers					16
17	Maintenance Workers	12,221	12,986	139,347	10.73	17
18	Housekeepers	20,487	21,555	156,626	7.27	18
19	Laundry	7,911	8,363	69,870	8.35	19
20	Administrator	2,119	2,198	61,229	27.86	20
21	Assistant Administrator	2,087	2,282	19,395	8.50	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,083	6,742	73,861	10.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,894	2,164	32,141	14.85	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	227,730	245,876	$ 2,909,194 *	$ 11.83	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	254	$ 12,629	01-03	35
36	Medical Director	Monthly	4,900	09-03	36
37	Medical Records Consultant	Monthly	3,164	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,225	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,130	11-03	44
45	Social Service Consultant	13	1,186	12-03	45
46	Other(specify)				46
47	Psycho-Social Consultant		575	12-03	47
48	See Attached		450	10-03	48
49	TOTAL (lines 35 - 48)	311	$ 27,259		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	47	$ 2,301	10-03	50
51	Licensed Practical Nurses	24	809	10-03	51
52	Nurse Aides	7	392	10-03	52
53	TOTAL (lines 50 - 52)	78	$ 3,502		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Corey Nigro (1/27-12/31/04)	Administrator	0	$ 48,893
Todd Tedrow (1/1-2/16/04)	Administrator	0	12,336
Nathan Langsner	Asst Admin	0	19,395
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,624

B. Administrative - Other

Description	Amount
Nathan Langsner - Management Fee	$ 48,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 48,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	Accounting	$ 18,000
Care Centers, Inc	Accounting	15,000
ADP	Payroll	10,138
Personnel Planners	Unemployment Consult	3,393
Care Centers, Inc	Bookkeeping	61,800
Legat Architects	Architect	4,807
Care Centers, Inc	Professional Services	1,200
Morton Cohen	Pharmacy Mgmt Consult	1,937
BDO Seidman	Accounting Line of Credit	250
SMS	Medicare Consultant	7,136
See Attached Schedule	Legal	9,700
See Supplemetal Schedule		13,230
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 146,591

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 98,105
Unemployment Compensation Insurance	57,016
FICA Taxes	220,505
Employee Health Insurance	127,414
Employee Meals	27,670
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	10,621
Employee Physicals	1,060
Pension Expense	25,044
Misc Employee Welfare	8,696
Holiday Expense	4,300
TOTAL (agree to Schedule V, line 22, col.8)	$ 580,431

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,132
Health Care Worker Background Check	2,160
(Indicate # of checks performed 195)	
Dues and Subscriptions	8,126
Licenses and Fees	4,195
Allocate Care Centers	2,998
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,611

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,728
Allocate Care Centers	4,300
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,028

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ILCLTC - $9,001**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,079** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **103,212**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **27,670** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.